Attachment A

SC Department of Disabilities and Special Needs
Report of Death

This form is to be completed on deaths of persons who reside in DDSN sponsored residential programs, or whose death occurs at a DDSN agency or provider location (e.g., day program), or while under the supervision of an agency or provider staff person (e.g., individual rehabilitation supports).

For consumers age 17 & under, use this form to report deaths:

- in DDSN operated homes or homes contracted for operation by DDSN (death must be reported to DDSN Director of Quality Management ASAP but no later than 24 hours).
- if death occurs in a location other than his/her DDSN sponsored home (e.g., hospital).

All deaths in ICF/MR facilities must be reported in writing to the Health Licensing Div of DHEC at the same time a report is made to DDSN.

Check any of these requirements that apply:

☐ *Reported to DDSN Director of Quality Management*
☐ *For ICF/MR, reported to DHEC*

For vulnerable adults age 18 and above, use this form to report deaths:

- in DDSN operated homes or those homes contracted for operation by DDSN (death must be reported to DDSN Director of Quality Management and to SLED ASAP but no later than 24 hours).
- if death occurs in a location other than his/her DDSN sponsored home (e.g., hospital).

All deaths in ICF/MR & CRCF facilities must be reported in writing to the Health Licensing Div of DHEC at the same time a report is made to DDSN.

Check any of these requirements that apply:

☐ *Reported to DDSN Director of Quality Management &*
☐ *Reported to SLED*
☐ *For ICF/MR & CRCF, reported to DHEC*

For consumers of any age, other than those living in a residential program operated by or contracted for operation by DDSN, use this form to report deaths occurring at an agency or provider location or while under the supervision of an agency or provider staff person. Death must be reported to Director of Quality Management ASAP but no later than 24 hours. *Reported to:* ☐ *DDSN Director of Quality Management*

If death was unexpected or suspicious in nature, the DDSN District Director (or designee) must be called immediately (within 2 hours of death). The District Director will then notify the Associate Director of Operations and the State Director. This form must be sent to Director of Quality Management ASAP but no later than 24 hours.

Name of Deceased:	First	Middle	Last
DOB: *(m/d/yy)*	***Age:***	***Sex:*** ☐ Male ☐ Female	***Race:*** ☐ White ☐Non White ☐ Other (specify):

Was consumer enrolled in the DDSN Waiver at the time of death? ☐ Yes ☐ No ☐ Don't Know
If yes, specify which waiver: ☐ MR/RD ☐ HASCI ☐ PDD ☐ Other:

Provider/Regional Center Reporting Death: _____ **County:**

☐ **District I:** ☐ Midlands ☐ Piedmont ☐ **District II:** ☐ Coastal ☐ Pee Dee

Type Facility: ☐ DDSN Contracted Provider ☐ DDSN Regional Center ☐ DDSN Operated Facility

Individual's residence:	***Descriptive location of residence:*** *(i.e., Smith CTH II)*	***How long has individual lived at this residence:***
☐ Lives at home with family/guardian or in own home ☐ CRCF ☐CTH-I ☐CTH-II ☐ ICF/MR ☐ SLP-I ☐SLP-II ☐ Unit @ Regional Center (ICF/MR) ☐ Other (specify):		

Location of death:	***Descriptive location of death:*** *(i.e., Smith CTH II)*
☐ At home with family or in own home ☐ CRCF ☐ CTH ☐ ICF ☐ SLP ☐ Day program ☐ Hospital ☐ Regional Center (ICF/MR) ☐ Other (specify):	

Primary medical diagnosis:
1. 2.
3. 4.

Did individual have: (Mark all that apply)
☐ N/G Tube ☐ G-Tube ☐ J-Tube ☐ J/G Tube ☐ Trach ☐ Seizures ☐ Dysphagia ☐ Gastro Reflux
☐ Nutritional Management Program *Indicate last Nutritional Management Evaluation date:*
Type of diet: *Time last ate:* *:* ☐ *AM* ☐ *PM*
Briefly describe Physical Management and Nutritional Management Plan/Program (If applicable):

Date of death: *(m/d/yy)*	***Time of Death:*** *:* ☐ AM ☐ PM	***Shift:*** *(If applicable)* ☐ 1st ☐ 2nd ☐ 3rd

Suspected Cause of Death:

Events leading to death *(use other side if necessary):*

Attending Physician*:*	***Autopsy done:*** ☐ Yes ☐ No If no, indicate reason:
Consent obtained: ☐ Yes ☐ No	***Coroner notified:*** ☐ Yes ☐ No

Parent/Guardian/Primary Correspondent:
Name
Address *When notified:* *By whom:*

Name: *Signature:* *Executive Director/ CEO/ Facility Administrator (or designee for Executive Director/ CEO/ Facility Administrator)*	Date ___/___/___

Send completed form (as indicated above) to:

- Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX # 803-898-7450
- SLED, when applicable, FAX # 803-896-8050
- Health Licensing Div of DHEC for ICF/MR's and CRCF's